FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042739

Facility Name: Lexington of Chicago Ridge

Address: 10300 Southwest Highway (Number) Chicago Ridge (City) 60145 (Zip Code)

County: Cook

Telephone Number: (708) 425-1100 **Fax #** (708) 425-0779

IDPA ID Number: 363734823001

Date of Initial License for Current Owners: 05/27/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,113	1,686	10,009	38,808	8
9	SNF/PED					9
10	ICF	30,896	2,017	748	33,661	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,009	3,703	10,757	72,469	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.64%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/4/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 9,267

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	296,451	31,389	16,957	344,797		344,797		344,797			1
2	Food Purchase		285,331		285,331		285,331	(11,124)	274,207			2
3	Housekeeping	272,564	41,703		314,267		314,267	390	314,657			3
4	Laundry	69,240	19,706		88,946		88,946	(1,750)	87,196			4
5	Heat and Other Utilities			175,746	175,746		175,746	3,911	179,657			5
6	Maintenance	68,750		112,766	181,516		181,516	3,439	184,955			6
7	Other (specify):*											7
8	**TOTAL General Services**	707,005	378,129	305,469	1,390,603		1,390,603	(5,134)	1,385,469			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,197,584	242,593	30,974	3,471,151		3,471,151		3,471,151			10
10a	Therapy			922,760	922,760		922,760		922,760			10a
11	Activities	174,803	13,776	3,184	191,763		191,763		191,763			11
12	Social Services	92,688		3,058	95,746		95,746		95,746			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,465,075	256,369	983,976	4,705,420		4,705,420		4,705,420			16
	C. General Administration											
17	Administrative	197,541		448,301	645,842		645,842	(448,301)	197,541			17
18	Directors Fees											18
19	Professional Services			46,764	46,764		46,764	11,971	58,735			19
20	Dues, Fees, Subscriptions & Promotions			13,352	13,352		13,352	856	14,208			20
21	Clerical & General Office Expenses	527,481	36,360	26,405	590,246		590,246	24,104	614,350			21
22	Employee Benefits & Payroll Taxes			732,662	732,662		732,662	79,731	812,393			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,287	3,287		3,287	2,968	6,255			24
25	Other Admin. Staff Transportation			44	44		44	9,803	9,847			25
26	Insurance-Prop.Liab.Malpractice			196,691	196,691		196,691	3,839	200,530			26
27	Other (specify):*											27
28	**TOTAL General Administration**	725,022	36,360	1,467,506	2,228,888		2,228,888	(315,029)	1,913,859			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,897,102	670,858	2,756,951	8,324,911		8,324,911	(320,163)	8,004,748			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Chicago Ridge #0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			59,738	59,738		59,738	178,944	238,682			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,208	13,208		13,208	328,817	342,025			32
33	Real Estate Taxes							550,886	550,886			33
34	Rent-Facility & Grounds			1,730,026	1,730,026		1,730,026	(1,730,026)				34
35	Rent-Equipment & Vehicles			5,936	5,936		5,936	4,256	10,192			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,808,908	1,808,908		1,808,908	(667,123)	1,141,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		243,973		243,973		243,973		243,973			39
40	Barber and Beauty Shops			22,020	22,020		22,020		22,020			40
41	Coffee and Gift Shops			3,630	3,630		3,630		3,630			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Costs			113,459	113,459		113,459	(113,459)				43
44	**TOTAL Special Cost Centers**		243,973	261,749	505,722		505,722	(113,459)	392,263			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,897,102	914,831	4,827,608	10,639,541		10,639,541	(1,100,745)	9,538,796			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,750)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,965)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(683)	43		13
14	Non-Care Related Interest	(1,025)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,230)	43		24
25	Fund Raising, Advertising and Promotional	(12,713)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,322)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(19,227)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (120,920)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(979,825)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (979,825)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,100,745)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/03 - 12/31/03

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Disallow nonallowable radiology	(13,450)	43
Disallow nonallowable laboratory	(3,771)	43
Nonallowable collection fees	(1,761)	19
Miscellaneous income	(360)	21
Deferred maintenance amort.	951	6
Various nonallowable expenses	(300)	43
Disallow out of period legal fees	(536)	19
Total	(19,227)	

See Accountants' Compilation Report

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5)	0	0	0	0	0	0	0	0	0	0	(5)	2
3	Housekeeping	0	0	390	0	0	0	0	0	0	0	0	390	3
4	Laundry	(1,750)	0	0	0	0	0	0	0	0	0	0	(1,750)	4
5	Heat and Other Utilities	0	0	3,911	0	0	0	0	0	0	0	0	3,911	5
6	Maintenance	0	0	2,488	0	0	0	0	0	0	0	0	2,488	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,755)	0	6,789	0	0	0	0	0	0	0	0	5,034	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(448,301)	0	0	0	0	0	0	0	(448,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,603	11,600	0	0	0	0	0	0	0	0	33,203	19
20	Fees, Subscriptions & Promotions	0	0	856	0	0	0	0	0	0	0	0	856	20
21	Clerical & General Office Expenses	0	224	24,240	0	0	0	0	0	0	0	0	24,464	21
22	Employee Benefits & Payroll Taxes	0	0	68,612	0	0	0	0	0	0	0	0	68,612	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,968	0	0	0	0	0	0	0	0	2,968	24
25	Other Admin. Staff Transportation	0	0	0	9,803	0	0	0	0	0	0	0	9,803	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,839	0	0	0	0	0	0	0	3,839	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	21,827	108,276	(434,659)	0	0	0	0	0	0	0	(304,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,755)	21,827	115,065	(434,659)	0	0	0	0	0	0	0	(299,522)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	146,953	0	31,991	0	0	0	0	0	0	0	178,944	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,990)	332,450	0	357	0	0	0	0	0	0	0	328,817	32
33	Real Estate Taxes	0	530,026	0	1,924	0	0	0	0	0	0	0	531,950	33
34	Rent-Facility & Grounds	0	(1,730,026)	0	0	0	0	0	0	0	0	0	(1,730,026)	34
35	Rent-Equipment & Vehicles	0	0	0	4,256	0	0	0	0	0	0	0	4,256	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,990)	(720,597)	0	38,528	0	0	0	0	0	0	0	(686,059)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(95,948)	11	0	0	0	0	0	0	0	0	0	(95,937)	43
44	**TOTAL Special Cost Centers**	(95,948)	11	0	0	0	0	0	0	0	0	0	(95,937)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,693)	(698,759)	115,065	(396,131)	0	0	0	0	0	0	0	(1,081,518)	45

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Chicago Ridge Limited Partnership	Chicago Ridge	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Chicago Ridge Limited Partnership	**	$ 21,603	$ 21,603	1
2	V	21	Office supplies expense		Sambell of Chicago Ridge Limited Partnership	**	114	114	2
3	V	30	Depreciation		Sambell of Chicago Ridge Limited Partnership	**	146,953	146,953	3
4	V	32	Interest expense		Sambell of Chicago Ridge Limited Partnership	**	329,241	329,241	4
5	V	32	Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	3,209	3,209	5
6	V	33	Property taxes		Sambell of Chicago Ridge Limited Partnership	**	530,026	530,026	6
7	V	34	Rental expense	1,730,026	Sambell of Chicago Ridge Limited Partnership	**		(1,730,026)	7
8	V	43	State replacement tax		Sambell of Chicago Ridge Limited Partnership	**	11	11	8
9	V	21	Bank charges		Sambell of Chicago Ridge Limited Partnership	**	110	110	9
10	V								10
11	V				** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V				of Sambell of Chicago Ridge Limited Partnership				12
13	V								13
14	Total			$ 1,730,026			$ 1,031,267	$ * (698,759)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/03 - 12/31/03

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 390	$ 390	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3841	3,841	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	70	70	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	2416	2,416	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	72	72	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	8740	8,740	20
21	V	19	Professional fees		Royal Management Corp.	**	2860	2,860	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	194	194	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	662	662	23
24	V	21	Bank charges		Royal Management Corp.	**	3360	3,360	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	7675	7,675	25
26	V	21	Postage		Royal Management Corp.	**	3452	3,452	26
27	V	21	Telephone		Royal Management Corp.	**	9753	9,753	27
28	V	22	FICA		Royal Management Corp.	**	30989	30,989	28
29	V	22	FUTA		Royal Management Corp.	**	557	557	29
30	V	22	SUTA		Royal Management Corp.	**	964	964	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	587	587	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	30626	30,626	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	4889	4,889	33
34	V	24	Travel & seminar		Royal Management Corp.	**	2968	2,968	34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 115,065	$ * 115,065	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 9,803	$ 9,803	15
16	V	26	Insurance general		Royal Management Corp.	**	3,839	3,839	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,400	3,400	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,950	7,950	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	20,641	20,641	19
20	V	32	Interest		Royal Management Corp.	**	357	357	20
21	V	33	Property taxes		Royal Management Corp.	**	1,924	1,924	21
22	V	35	Equipment rental		Royal Management Corp.	**	4,256	4,256	22
23	V	17	Management fees	448,301	Royal Management Corp.	**		(448,301)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V		**Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.						37
38	V								38
39	Total			$ 448,301			$ 52,170	$ * (396,131)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/03 - 12/31/03

Schedule C

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	177,833	284,532	142,266	42,680	108,478	755,789

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/Officer	Administrative	22.33%	See Schedule C	4	8%	Salary	$ 35,468	L17, C1	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule C	3	6%	Salary	22,167	L17, C1	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule C	2	5%	Salary	17,734	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4%	Salary	5,320	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	13,522	L17, C1	5
6											6
7											7
8					All individuals work in excess of 40 hours per week.						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,211		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	81,760	$ 390	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		81,760	3,841	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		81,760	70	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		81,760	2,416	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		81,760	72	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		81,760	8,740	6
7	19	Professional fees	Bed Days	737,665	10	25,806		81,760	2,860	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		81,760	194	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		81,760	662	9
10	21	Bank charges	Bed Days	737,665	10	30,319		81,760	3,360	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		81,760	7,675	11
12	21	Postage	Bed Days	737,665	10	31,145		81,760	3,452	12
13	21	Telephone	Bed Days	737,665	10	87,995		81,760	9,753	13
14	22	FICA	Bed Days	737,665	10	279,595		81,760	30,989	14
15	22	FUTA	Bed Days	737,665	10	5,021		81,760	557	15
16	22	SUTA	Bed Days	737,665	10	8,695		81,760	964	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		81,760	587	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		81,760	30,626	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		81,760	4,889	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		81,760	2,968	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 115,065	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	81,760	$ 9,803	1
2	26	Insurance general	Bed Days	737,665	10	34,634		81,760	3,839	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		81,760	3,400	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		81,760	7,950	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		81,760	20,641	5
6	32	Interest	Bed Days	737,665	10	3,219		81,760	357	6
7	33	Property taxes	Bed Days	737,665	10	17,360		81,760	1,924	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		81,760	4,256	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 52,170	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, L.L.C.	X		Mortgage	$42,300.00	12/29/98	5,563,000	4,795,368	01/01/08	0.0675	329,241	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank, N.A.		X	Working capital	Varies	04/06/02	1,000,000		4/4/04	Prime	12,183	6
7	Shareholders	X		Working capital	Varies	04/30/03	200,000		Demand	0.0425	1,025	7
8												8
9	TOTAL Facility Related				$42,300.00		$ 6,763,000	$ 4,795,368			$ 342,449	9
	B. Non-Facility Related*											
10							Amortization of mortgage of costs				3,209	10
11							Interest income offset				(2,965)	11
12							Allocated from management company				357	12
13							Nonallowable shareholder interest				(1,025)	13
14	TOTAL Non-Facility Related						$	$			$ (424)	14
15	TOTALS (line 9+line14)						$ 6,763,000	$ 4,795,368			$ 342,025	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 547,000	1
	Allocation from management company	1,924	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 551,245	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,169	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 565,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$ 18,936	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	R/E/T Refund for 1996	(1,480)	
	R/E/T Refund for 1999-2001	(37,939)	
TOTAL REFUND $ 39,419 For see above Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 550,886	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	442,475	8
	1999	462,509	9
	2000	478,861	10
	2001	499,417	11
	2002	551,245	12

2002 taxes:	551,245
Estimated increase:	1.025
Estimated 2003 taxes:	565,026
Use:	565,200

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Chicago Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-200-030-0000	Land & Building	$ 551,244.86	$ 551,244.86
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 212,239.00	$ 1,924.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 763,483.86	$ 553,168.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	31,000	1989	$ 505,000	1
2	Allocation from management company			17,683	2
3	TOTALS	31,000		$ 522,683	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1991	1991	$ 5,143,342	$	35	$ 146,953	$ 146,953	$ 1,849,155	4
5	9		1995	1995	97,352	2,781	35	2,781		23,642	5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	2,694	78	35	78		810	9
10	Leasehold Improvements			1994	6,581	188	35	188		1,786	10
11	Dishwasher hood			1996	2,480	248	10	248		1,860	11
12	Lobby repairs			1996	8,698	870	10	870		6,524	12
13	Basement rehab			1997	24,477	2,448	10	2,448		16,726	13
14	Wiring			1998	3,428	343	10	343		1,886	14
15	Handrails			1998	895	60	15	60		329	15
16	Resurface & restripe parking lot			1998	4,450	445	10	445		2,447	16
17	Fire wall			1998	2,169	62	35	62		341	17
18	Foyer floor tile			1999	32,379	3,238	10	3,238		15,650	18
19	Wallpapering / painting / decorating			1999	8,833	883	10	883		3,754	19
20	Rebuild garage area			1999	1,762	50	35	50		209	20
21	Roof repairs			2000	6,240	624	10	624		2,184	21
22	Electrical wiring			2000	3,986	114	35	114		399	22
23	Electrical wiring			2000	2,536	72	35	72		253	23
24	Kitchen rehab			2000	6,623	221	35	221		773	24
25	Automatic doors			2000	1,300	130	10	130		455	25
26	Elevator eye sensors			2000	4,500	300	15	300		1,050	26
27	Resurface & restripe parking lot			2001	3,319	332	10	332		830	27
28	Door releases			2001	5,200	520	10	520		1,300	28
29	Carpeting			2001	10,022	1,002	10	1,002		2,505	29
30	Roof repairs			2002	25,600	1,280	20	1,280		2,347	30
31	Elevator upgrade			2002	9,866	986	10	986		1,562	31
32	Painting/decorating/carpet/wallpaper			2003	38,165	1,908	20	1,908		1,908	32
33	Rehab/new office			2003	26,733	1,337	20	1,337		1,337	33
34	Facility rehab - construction costs, painting & decorating			2003	257,174	6,429	20	6,429		6,429	34
35	Facility rehab - electrical			2003	12,840	321	20	321		321	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Facility rehab - carpeting	2003	$ 7,800	$ 390	10	$ 390	$	$ 390	37
38	Facility rehab - floor tile	2003	3,548	89	20	89		89	38
39									39
40									40
41									41
42	Leasehold improvements - management company	1995	11,208		35	332	332	2,722	42
43	Leasehold improvements - management company	1996	9,121		35	270	270	1,955	43
44	Leasehold improvements - management company	1989	314		31	9	9	158	44
45	HVAC - management company	1998	236		35	7	7	40	45
46	Offices - management company	1999	596		35	18	18	77	46
47	Land improvements - management company	2002	27,870		15	826	826	3,561	47
48	Building - management company	2002	216,828		40	6,415	6,415	10,390	48
49	HVAC, electrical, security system - management company	2003	2,149		30	55	55	55	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,033,314	$ 27,749		$ 182,634	$ 154,885	$ 1,968,209	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 223,655	$ 25,225	$ 25,225	$	5-10 yrs	$ 155,223	71
72	Current Year Purchases	111,183	6,782	6,782		3-10 yrs	6,782	72
73	Fully Depreciated Assets	387,035					387,035	73
74	Allocated from Mgmt Co.	198,468		20,641	20,641		65,776	74
75	TOTALS	$ 920,341	$ 32,007	$ 52,648	$ 20,641		$ 614,816	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	1994 Infiniti	1994	$ 19,313	$	$	$	5	$ 19,313	76
77										77
78										78
79	Allocated from Mgmt Co.			33,164		3,400	3,400		26,478	79
80	TOTALS			$ 52,477	$	$ 3,400	$ 3,400		$ 45,791	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	7,528,815	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	59,756	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	238,682	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	178,926	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,628,816	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,192 Description: Copier: $5,936; Allocation from management company: $4,256
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	8,255	$ 390,262	$	8,255	$ 390,262	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		218	15,416		218	15,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		9,326	509,400		9,326	509,400	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				243,973		243,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound Therapy	L10A, C3				7,682			7,682	13
14	TOTAL			$	17,799	$ 922,760	$ 243,973	17,799	$ 1,166,733	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (6,866)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 815,603)	1,750,881	1,750,881	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,186	65,186	6
7	Other Prepaid Expenses	5,312	5,312	7
8	Accounts Receivable (owners or related parties)	73,761	73,761	8
9	Other(specify): Escrow		114,693	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,888,274	$ 2,009,833	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,357	7,357	12
13	Land		522,683	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	621,650	889,972	15
16	Equipment, at Historical Cost	331,772	972,818	16
17	Accumulated Depreciation (book methods)	(262,105)	(2,628,816)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		48,128	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 698,674	$ 4,955,484	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,586,948	$ 6,965,317	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 547,476	$ 547,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	270,885	270,885	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,409	1,409	31
32	Accrued Real Estate Taxes(Sch.IX-B)		565,200	32
33	Accrued Interest Payable		26,974	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	536,202	103,328	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,355,972	$ 1,515,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,795,368	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,795,368	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,355,972	$ 6,310,640	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,230,976	$ 654,677	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,586,948	$ 6,965,317	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/03 - 12/31/03

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	432,874	
Accrued management fees	36,166	36,166
Accrued 401(k) contribution	27,003	27,003
Due to related party	60	60
Other accrued expenses	40,099	40,099
Total line 36	536,202	103,328

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment Income in Lexington Financial Services II, LLC	413
State bedhold Income	750
Miscellaneous Income	360
Total line 28	1,523

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 972,449	1
2	Restatements (describe):		2
3			3
4	Prior year's post closing entries	606	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 973,055	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	453,008	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(195,087)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 257,921	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,230,976	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,889,762	1
2	Discounts and Allowances for all Levels	(934,423)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,955,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,714,222	6
7	Oxygen	490	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,714,712	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,841	12
13	Barber and Beauty Care	25,386	13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio	18	15
16	Rental of Facility Space		16
17	Sale of Drugs	288,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,591	19
20	Radiology and X-Ray	13,777	20
21	Other Medical Services	60,719	21
22	Laundry	1,750	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 418,010	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,965	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,965	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	1,523	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,523	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,092,549	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,390,603	31
32	Health Care	4,705,420	32
33	General Administration	2,228,888	33
	B. Capital Expense		
34	Ownership	1,808,908	34
	C. Ancillary Expense		
35	Special Cost Centers	383,082	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,639,541	40
41	**Income before Income Taxes (line 30 minus line 40)****	453,008	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 453,008	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,240	2,613	$ 95,937	$ 36.72	1
2	Assistant Director of Nursing	3,990	4,442	143,417	32.29	2
3	Registered Nurses	53,279	54,286	1,531,207	28.21	3
4	Licensed Practical Nurses	5,546	6,093	131,423	21.57	4
5	Nurse Aides & Orderlies	96,443	104,134	1,168,866	11.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,264	10,425	126,734	12.16	8
9	Activity Director	1,364	1,752	20,885	11.92	9
10	Activity Assistants	14,958	16,296	153,918	9.45	10
11	Social Service Workers	4,473	4,738	92,688	19.56	11
12	Dietician					12
13	Food Service Supervisor	2,269	2,481	24,800	10.00	13
14	Head Cook	2,224	2,494	25,414	10.19	14
15	Cook Helpers/Assistants	12,885	14,177	114,286	8.06	15
16	Dishwashers	20,088	21,587	131,951	6.11	16
17	Maintenance Workers	3,818	4,366	68,750	15.75	17
18	Housekeepers	37,149	40,250	272,564	6.77	18
19	Laundry	9,851	10,637	69,240	6.51	19
20	Administrator	1,248	1,806	103,330	57.21	20
21	Assistant Administrator					21
22	Other Administrative	714	717	94,211	131.40	22
23	Office Manager					23
24	Clerical	21,585	25,739	527,481	20.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	303,388	329,033	$ 4,897,102 *	$ 14.88	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	295	$ 16,383	L1, C3	35
36	Medical Director	12	24,000	L9, C3	36
37	Medical Records Consultant	13	650	L10, C3	37
38	Nurse Consultant	47	1,406	L10, C3	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	3,184	L11, C3	44
45	Social Service Consultant	67	3,058	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	512	$ 49,881		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Cecconi	Administrator	0.00%	$ 30,000
Marichu Bueno	Administrator	0.00%	73,330
John Samatas	Admin/Plant Ops	22.33%	22,167
James Samatas	Administrative	22.33%	35,468
Cynthia Thiem	Administrative	22.34%	17,734
George Samatas	Administrative	0.00%	5,320
Jason Samatas	Administrative	0.00%	13,522
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 197,541

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 448,301
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 448,301

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	$ 435
Altschuler, Melvoin & Glasser LLP	Accounting	15,667
American Express Tax & Bus. Svcs.	Accounting	5,511
Freedman, Anselmo & Lindberg	Collections	36
Family Center for Elder Law	Legal	1,300
James Samatas	Legal	68
Personnel Planners	U/C Consulting	1,287
Carol Jeschke	Staffing Consultant	1,323
Sachnoff & Weaver	Legal	6,787
Gilson, Labus & Silverman	Accounting	78
Harris, Kessler & Goldstein	Legal	1,039
See attached Schedule F		13,233
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 46,764

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,708
Unemployment Compensation Insurance	26,511
FICA Taxes	360,214
Employee Health Insurance	300,752
Employee Meals	11,119
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	29,798
Other Employee Benefits	8,291
TOTAL (agree to Schedule V, line 22, col.8)	$ 812,393

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,585
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Dues & Subs	124
Miscellaneous Licenses & Permits	1,643
Allocated from management company	856
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,208

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,287
Allocated from management company	2,968
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,255

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996 **Schedule F**
1/1/03- 12/31/03

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Nyemaster, Goode, Voigts, West, Hansell & O'Brien	Legal	850
Katten Muchin Zavis Rosenman	Legal	4,704
eHealth Solutions	Computer Services	1,080
Advanced Answers on Demand, Inc.	Computer Services	2,652
Administar	Computer Services	378
Gigatrend	Computer Services	195
KraKau Business	Computer Services	493
Information Controls, Inc.	Computer Services	1,156
Various	Collections	1,725
		13,233
Total, Agrees to Schedule V, Line 19, Column 3		46,764
Allocated from management co.		
American Express Tax & Business Services	Accounting	623
Gilson, Labus and Silverman	Accounting	57
James Samatas	Legal	77
Katten, Muchin, Zavis and Rosenman	Legal	72
Sachnoff and Weaver	Legal	566
ING / Pension Administrators	401 (k) Administration	764
Personnel Planners	U/C Consulting	27
Various	Consulting	674
Various	Computer Consulting	8,740
Allocated from building partnership		
James Samatas	Filing and recording fees	168
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	18,936
Associated Property Counselors	Appraisal fees	2,500
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Collection fees	(36)
Various	Collection fees	(1,725)
Disallow out of period legal fees		
Family Center for Elder Law	Out of period fees	(250)
Katten, Muchin, Zavis and Rosenman	Out of period fees	(286)
Reclassifications		
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	(18,936)
Total, Agrees to Schedule V, Line 19, Column 8		58,735

See Accountants' Compilation Report.

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Deferred painting & dec	12/00	$ 2,198	3 yrs	$ 367	$ 732	$ 732	$ 367	$	$	$	$	$
2	Deferred painting & dec	12/00	3,503	3 yrs	583	1,168	1,168	584					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,701		$ 950	$ 1,900	$ 1,900	$ 951	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,028** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,119** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Chicago R 12:21 PM 11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	Explanation
Adjustment Detail	-1,100,745	equal to	-1,100,745	0	O.K.	
Interest Expense	342,025	equal to	342,025	0	O.K.	
Real Estate Tax Expenses	550,886	equal to	550,886	0	O.K.	
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	
Ownership Costs-Depreciation	238,682	equal to	238,682	0	O.K.	
Rental Costs A	0	equal to	0	0	O.K.	
Rental Costs B	10,192	equal to	10,192	0	O.K.	
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	
Special Serv.- Staff Wages		equal to		0	O.K.	
Therapy Services	922,760	equal to	922,760	0	O.K.	
Special Serv.- Supplies	243,973	equal to	#VALUE!	#VALUE!	#VALUE!	ok
Income Stat. General Serv.	1,390,603	equal to	1,390,603	0	O.K.	
Income Stat. Health Care	4,705,420	equal to	4,705,420	0	O.K.	
Income Stat. Admininstation	2,228,888	equal to	2,228,888	0	O.K.	
Income Stat. Ownership	1,808,908	equal to	1,808,908	0	O.K.	
Income Stat. Special Cost Ctr	383,082	equal to	383,082	0	O.K.	
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	
Staff- Nursing	3,070,850	equal to	3,197,584	-126,734	FAILED	ok, therapy aids on pg. 20, line 8 for $126,734
Staff- Nurse aide Training	0	< or = to		0	O.K.	
Staff-Licensed Therapist	0	equal to		0	O.K.	
Staff- Activities	174,803	equal to	174,803	0	O.K.	
Staff- Social Serv. Workers	92,688	equal to	92,688	0	O.K.	
Staff- Dietary	296,451	equal to	296,451	0	O.K.	
Staff- Maintenance	68,750	equal to	68,750	0	O.K.	
Staff- Housekeeping	272,564	equal to	272,564	0	O.K.	
Staff- Laundry	69,240	equal to	69,240	0	O.K.	
Staff- Administrative	197,541	equal to	197,541	0	O.K.	
Staff- Clerical	527,481	equal to	527,481	0	O.K.	
Staff- Medical Director	0	equal to		0	O.K.	
Total Salaries And Wages	4,897,102	equal to	4,897,102	0	O.K.	
Dietary Consultant	16,383	< or = to	16,957	-574	O.K.	ok, other dietary supplies for $574 included on line 3
Medical Director	24,000	< or = to	24,000	0	O.K.	
Consultants & contractors	3,256	< or = to	30,974	-27,718	O.K.	ok, includes oxygen & med equip rental of $27,718
Activity Consultant	3,184	< or = to	3,184	0	O.K.	
Social Service Consultant	3,058	< or = to	3,058	0	O.K.	
Supp. Sched.- Admin. Salar.	197,541	equal to	197,541	0	O.K.	
Supp. Sched.- Admin. Other	448,301	equal to	448,301	0	O.K.	
Supp. Sched.- Prof. Serv.	46,764	equal to	46,764	0	O.K.	
Professional Fees - pg.3, column 8/sch	58,735	equal to	58,735	0	O.K.	
Supp. Sched.- Benefit/Taxes	812,393	equal to	812,393	0	O.K.	
Supp. Sched.- Sched of dues..	14,208	equal to	14,208	0	O.K.	
Supp. Sched.- Sched. of trav	6,255	equal to	6,255	0	O.K.	
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	
Gen. Info - Employee Meals	11,119	< or = to	79,731	-68,612	O.K.	ok, employee meals = $11,119
Gen. Info - Employee Meals	11,119	equal to	11,119	0	O.K.	
Nurse aide training	0	equal to		0	O.K.	
Days of medicare provided	9,267	equal to	10,009	-742	FAILED	ok, 9,267 days of Medicare
Adjustment for related org. costs	-979,825	equal to	-979,825	0	O.K.	
Total loan balance	4,795,368	equal to	4,795,368	0	O.K.	
Real estate tax accrual	565,200	equal to	565,200	0	O.K.	
Land	522,683	equal to	522,683	0	O.K.	
Building cost	6,033,314	equal to	6,033,314	0	O.K.	
Equipment and vehicle cost	972,818	equal to	972,818	0	O.K.	
Accumulated depr.	2,628,816	equal to	2,628,816	0	O.K.	
End of year equity	1,230,976	equal to	1,230,976	0	O.K.	
Net income (loss)	453,008	equal to	453,008	0	O.K.	
Unamortized deferred maint. cost	0	equal to		0	O.K.	
Balance Sheet	2,586,948	equal to	2,586,948	0	O.K.	

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!!**		11/4/2005	12:21:50 PM			
HSA Number	?	Name	**Lexington of Chicago Ridge**				
Cost report period	From:	01/01/03	To:	12/31/03	Base Number		336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	81,760	Occupancy:	72,469	Pct. of occupancy:		88.64%	
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	707,005	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	725,022	Col 1, Line 28 ---Audit Adj					
Total Salary Wage	4,897,102	Col 1, Line 44 ---Audit Adj					
Employee Benefits	812,393	Col 8, Line 22 ---Audit Adj					
Total General Services:	1,385,469	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,913,859	Col 8, Line 28 ---Audit Adj					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$707,005
Divided by Total Wages (Column 1, Line 44	$4,897,102
General service wages as percent of total wages	14.4372%
Employee Benefits (Column 10, Line 22	$812,393
Allocation of Employee Benefits to General Services Costs	$117,287
Plus Total General Services (Column 10, Line 8	$1,385,469
New Total General Services Cost	$1,502,756

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$725,022
Divided by Total Wages (Column 1, Line 45	$4,897,102
General administration wages as a percent of total wages	14.8051%
Employee Benefits (Column 10, Line 22	$812,393
Allocation of Emplayee Benefits to General Admin. Cost	$120,276
Plus Total General Administration (Column 10, Line 2	$1,913,859
Minus Total Fringe (Column 10, Line 2:	$812,393
New Total General Administration Cos	$1,221,742

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,502,756	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,502,756

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$1,221,742	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$1,221,742
3 Total Updated Support Costs (1 + 2		$2,724,498

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $36.99

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,724,498
Total Patient Days (Cost Report	72,469
Support Costs per Diem	$37.60

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	81,760
Multiplied by	0.93
	76,037
Minus total Patient Days	72,469
	3,568
One-third of difference	1,189
Plus Total Patient Day	72,469
Adjusted Occupancy	73,658
Total Support Costs (Step II, C, 3, above	$2,724,498
Divided by Adjusted Occupany	73658
Support Costs Per Diem	$36.99

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$36.99
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Diem	$36.99
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$36.99
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Diem	$36.99
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abo **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 12:21:50 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington of Chicago Ridge** ID: **0042739**

HSA No.: ? Own or Rent? (O or R) ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented
from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings
constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	224	Total Patient Days	72,469
Begin	**01/01/03**	Licensed Bed Days:	81,760	% Occupied	88.64%
End	**12/31/03**			Capital Days	76,037

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1992
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	6033314
2. Total licensed beds from cost report Page 2, Line 7, column 3	224
3. Line 1 divided by Line 2	$26,934
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	76,037
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	72,469
2. Total Licensed Bed Days * .93	76037
3. Capital Days (higher of Line 1 or Line 2)	76,037

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	91	5143342	468044122	12
2	2	95	97352	9248440	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	93	2694	250542	12
7	7	94	6581	618614	12
8	8	96	2480	238080	12
9	9	96	8698	835008	12
10	10	97	24477	2374269	12
11	11	98	3428	335944	12
12	12	98	895	87710	12
13	13	98	4450	436100	12
14	14	98	2169	212562	12
15	15	99	32379	3205521	12
16	16	99	8833	874467	12
17	17	99	1762	174438	12
18	18	100	6240	624000	12
19	19	100	3986	398600	12
20	20	100	2536	253600	12
21	21	100	6623	662300	12
22	22	100	1300	130000	12
23	23	100	4500	450000	12
24	24	101	3319	335219	12
25	25	101	5200	525200	12
26	26	101	10022	1012222	12
27	27	102	25600	2611200	12
28	28	102	9866	1006332	12
29	29	103	38165	3930995	12
30	30	103	26733	2753499	12
31	31	103	257174	26488922	12
32	32	103	12840	1322520	12
33	33	0	0	0	12
34	34	103	7800	803400	12A
35	35	103	3548	365444	12A
36	36	0	0	0	12A
37	37	0	0	0	12A
38	38	0	0	0	12A
39	39	95	11208	1064760	12A
40	40	96	9121	875616	12A
41	41	89	314	27946	12A
42	42	98	236	23128	12A
43	43	99	596	59004	12A
44	44	102	27870	2842740	12A
45	45	102	216828	22116456	12A
46	46	103	2149	221347	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

557840267 6033314 92.46000904

Base Year = 1992

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	296,451	31,389	16,957	344,797	0	344,797	0	344,797
2. Food Purchase	0	285,331	0	285,331	0	285,331	-11,124	274,207
3. Housekeeping	272,564	41,703	0	314,267	0	314,267	390	314,657
4. Laundry	69,240	19,706	0	88,946	0	88,946	-1,750	87,196
5. Heat and Other Utilities	0	0	175,746	175,746	0	175,746	3,911	179,657
6. Maintenance	68,750	0	112,766	181,516	0	181,516	3,439	184,955
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	707,005	378,129	305,469	1,390,603	0	1,390,603	-5,134	1,385,469
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	3,197,584	242,593	30,974	3,471,151	0	3,471,151	0	3,471,151
10a. Therapy	0	0	922,760	922,760	0	922,760	0	922,760
11. Activities	174,803	13,776	3,184	191,763	0	191,763	0	191,763
12. Social Services	92,688	0	3,058	95,746	0	95,746	0	95,746
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,465,075	256,369	983,976	4,705,420	0	4,705,420	0	4,705,420
17. Administrative	197,541	0	448,301	645,842	0	645,842	-448,301	197,541
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	46,764	46,764	0	46,764	11,971	58,735
20. Fees, Subscriptions & Promotion	0	0	13,352	13,352	0	13,352	856	14,208
21. Clerical & General Office	527,481	36,360	26,405	590,246	0	590,246	24,104	614,350
22. Employee Benefits & Payroll	0	0	732,662	732,662	0	732,662	79,731	812,393
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,287	3,287	0	3,287	2,968	6,255
25. Other Admin. Staff Trans	0	0	44	44	0	44	9,803	9,847
26. Insurance-Prop.Liab.Malpractice	0	0	196,691	196,691	0	196,691	3,839	200,530
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	725,022	36,360	1,467,506	2,228,888	0	2,228,888	-315,029	1,913,859
29. Total General Administrative	4,897,102	670,858	2,756,951	8,324,911	0	8,324,911	-320,163	8,004,748
30. Depreciation	0	0	59,738	59,738	0	59,738	178,944	238,682
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	13,208	13,208	0	13,208	328,817	342,025
33. Real Estate	0	0	0	0	0	0	550,886	550,886
34. Rent - Facility & Grounds	0	0	1,730,026	1,730,026	0	1,730,026	-1,730,026	0
35. Rent - Equipment & Vehicles	0	0	5,936	5,936	0	5,936	4,256	10,192
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,808,908	1,808,908	0	1,808,908	-667,123	1,141,785
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	243,973	0	243,973	0	243,973	0	243,973
40. Barber and Beauty Shop	0	0	22,020	22,020	0	22,020	0	22,020
41. Coffee and Gift Shops	0	0	3,630	3,630	0	3,630	0	3,630
42. Provider Participation	0	0	122,640	122,640	0	122,640	0	122,640
43. Other (specify):*	0	0	113,459	113,459	0	113,459	-113,459	0
44. Total Special Cost Ce	0	243,973	261,749	505,722	0	505,722	-113,459	392,263
45. Grand Total	4,897,102	914,831	4,827,608	10,639,541	0	10,639,541	-1,100,745	9,538,796

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-6,866	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,750,881	1,750,881
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	65,186	65,186
7. Other Prepaid Expenses	5,312	5,312
8. Accounts Receivable-Owner/Related Party	73,761	73,761
9. Other (specify):	0	114,693
10. Total current assets	1,888,274	2,009,833
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	7,357	7,357
13. Land	0	522,683
14. Buildings, at Historical Cost	0	5,143,342
15. Leasehold Improvements, Historical Cost	621,650	889,972
16. Equipment, at Historical Cost	331,772	972,818
17. Accumulated Depreciation (book methods)	-262,105	-2,628,816
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	48,128
24. Total Long-Term Assets	698,674	4,955,484
25. Total Assets	2,586,948	6,965,317
CURRENT LIABILITIES		
26. Accounts Payable	547,476	547,476
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	270,885	270,885
31. Accrued Taxes Payable	1,409	1,409
32. Accrued Real Estate Taxes	0	565,200
33. Accrued Interest Payable	0	26,974
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	536,202	103,328
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,355,972	1,515,272
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,795,368
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,795,368
46.Total Liabilities	1,355,972	6,310,640
47.Total Equity	1,230,976	654,677
48.Total Liabilities and Equity	2,586,948	6,965,317

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	9,889,762
2. Discounts and Allowances for all Levels	-934,423
Subtotal - Inpatient Care	8,955,339
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,714,222
7. Oxygen	490
Subtotal - Anciliary Revenue	1,714,712
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	3,841
13. Barber and Beauty Care	25,386
14. Non-Patient Meals	5
15. Telephone, Television, and Radio	18
16. Rental of Facility Space	0
17. Sale of Drugs	288,923
18. Sale of Supplies to Non-Patients	0
19. Laboratory	23,591
20. Radiologyand X-Ray	13,777
21. Other Medical Services	60,719
22. Laundry	1,750
Subtotal - Other Operating Revenue	418,010
24. Contributions	0
25. Interest and Other Investments Income	2,965
Subtotal - Non-Operating Revenue	2,965
27. Other Revenue (specify):	1,523
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,523
30. Total Revenue	11,092,549
31. General Services	1,390,603
32. Health Care	4,705,420
33. General Administration	2,228,888
34. Ownership	1,808,908
35. Special Cost Centers	383,082
35. Provider Participation Fee	122,640
37. Other	0
40. Total Expenses	10,639,541
41. Income Before Income Taxes	453,008
42. Income Taxes	0
43. Net Income or Loss for the Year	453,008

Page	
1	
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18	
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20	
21	
22	
23	Provider Participation fee is linked from page 4